		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027565

Facility Name: ManorCare at Urbana

Address: 600 N. Coler Ave (Number) Urbana (City) 61801 (Zip Code)

County: Champaign

Telephone Number: (217) 367-1191 **Fax #** (217) 344-4082

IDPA ID Number: 520886946007

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419)252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/02 to 05/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,299	2,580	8,188	16,067	8
9	SNF/PED					9
10	ICF	14,544	3,037		17,581	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,843	5,617	8,188	33,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.19%

D. How many bed-hold days during this year were paid by Public Aid?
62 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 6,328

Medicare Intermediary Carefirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/03 Fiscal Year: 5/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ManorCare at Urbana # 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,930	15,340	7,879	227,149	1,564	228,713		228,713			1
2	Food Purchase		152,431		152,431		152,431	(1,940)	150,491			2
3	Housekeeping	104,172	13,385	1,869	119,426		119,426		119,426			3
4	Laundry	38,335	14,921	1,445	54,701		54,701		54,701			4
5	Heat and Other Utilities			98,588	98,588	6,372	104,960	(5,241)	99,719			5
6	Maintenance	35,689	7,042	58,798	101,529		101,529		101,529			6
7	Other (specify):*			1,306	1,306		1,306		1,306			7
8	**TOTAL General Services**	382,126	203,119	169,885	755,130	7,936	763,066	(7,181)	755,885			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,366,616	126,292	21,507	1,514,415	27,137	1,541,552		1,541,552			10
10a	Therapy	355,039	5,855	28,795	389,689		389,689		389,689			10a
11	Activities	42,844	3,480	2,469	48,793		48,793		48,793			11
12	Social Services	78,421	278	1,202	79,901		79,901		79,901			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,842,920	135,905	62,973	2,041,798	27,137	2,068,935		2,068,935			16
	C. General Administration											
17	Administrative	57,459		301,592	359,051	(149,878)	209,173		209,173			17
18	Directors Fees											18
19	Professional Services			3,337	3,337	(2,885)	452	(452)				19
20	Dues, Fees, Subscriptions & Promotions			34,742	34,742		34,742	(16,098)	18,644			20
21	Clerical & General Office Expenses	200,452	31,813	103,842	336,107	2,885	338,992	(40,526)	298,466			21
22	Employee Benefits & Payroll Taxes			645,450	645,450	48,815	694,265		694,265			22
23	Inservice Training & Education			105	105		105		105			23
24	Travel and Seminar			16,804	16,804		16,804		16,804			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,653	85,653		85,653		85,653			26
27	Other (specify):*											27
28	**TOTAL General Administration**	257,911	31,813	1,191,525	1,481,249	(101,063)	1,380,186	(57,076)	1,323,110			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,482,957	370,837	1,424,383	4,278,177	(65,990)	4,212,187	(64,257)	4,147,930			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ManorCare at Urbana #0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,616	46,616	30,865	77,481		77,481			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					35,125	35,125	(7,086)	28,039			32
33	Real Estate Taxes			73,129	73,129		73,129	23,764	96,893			33
34	Rent-Facility & Grounds			45,000	45,000		45,000		45,000			34
35	Rent-Equipment & Vehicles			15,013	15,013		15,013		15,013			35
36	Other (specify):*											36
37	**TOTAL Ownership**			179,758	179,758	65,990	245,748	16,678	262,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		190,061	17,013	207,074		207,074		207,074			39
40	Barber and Beauty Shops			10,404	10,404		10,404		10,404			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):*		39,678		39,678		39,678		39,678			43
44	**TOTAL Special Cost Centers**		229,739	82,167	311,906		311,906		311,906			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,482,957	600,576	1,686,308	4,769,841		4,769,841	(47,579)	4,722,262			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,940)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,241)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,086)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,275)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,926)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,720)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(452)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,593)	21		24
25	Fund Raising, Advertising and Promotional	(16,098)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	23,764	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,579)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (47,579)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ManorCare at Urbana

ID# 0027565

Report Period Beginning: 06/01/02

Ending: 05/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ManorCare at Urbana # 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,940)	0	0	0	0	0	0	0	0	0	0	(1,940)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,241)	0	0	0	0	0	0	0	0	0	0	(5,241)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,181)	0	0	0	0	0	0	0	0	0	0	(7,181)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(452)	0	0	0	0	0	0	0	0	0	0	(452)	19
20	Fees, Subscriptions & Promotions	(16,098)	0	0	0	0	0	0	0	0	0	0	(16,098)	20
21	Clerical & General Office Expenses	(40,526)	0	0	0	0	0	0	0	0	0	0	(40,526)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(57,076)	0	0	0	0	0	0	0	0	0	0	(57,076)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,257)	0	0	0	0	0	0	0	0	0	0	(64,257)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number ManorCare at Urbana **#** 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,086)	0	0	0	0	0	0	0	0	0	0	(7,086)	32
33	Real Estate Taxes	23,764	0	0	0	0	0	0	0	0	0	0	23,764	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	16,678	0	0	0	0	0	0	0	0	0	0	16,678	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,579)	0	0	0	0	0	0	0	0	0	0	(47,579)	45

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 301,592	HCR Manor Care, Inc	100.00%	$ 301,592	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	27,932	Heartland Management Services	100.00%	27,932		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 329,524			$ 329,524	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	920,912	536,824	4,562,440	1,564	2
3	5	Utilities - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	112,862		4,562,440	226	3
4	5	Utilities - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	3,618,915		4,562,440	6,146	4
5	10	Nursing - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	11,131,912	7,408,777	4,562,440	22,309	5
6	10	Nursing - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	2,842,925	1,812,855	4,562,440	4,828	6
7	17	General & Admin - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	19,326,083	15,188,841	4,562,440	38,730	7
8	17	General & Admin - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	66,522,981	38,146,902	4,562,440	112,981	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	2,749,439		4,562,440	5,510	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	25,498,075		4,562,440	43,305	10
11	30	Depreciation - Direct	Accumulated Cost	2,276,617,075	369 Nurs Fac.	148,355		4,562,440	297	11
12	30	Depreciation - Pooled	Accumulated Cost	2,686,344,447	369 Nurs Fac.	17,998,306		4,562,440	30,568	12
13										13
14	32	Interest				7,352,132			35,125	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 158,222,897	$ 63,094,199		$ 301,589	25

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 871,900	$ 871,900			$ 35,125	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(7,086)	8
9	TOTAL Facility Related						$ 871,900	$ 871,900			$ 28,039	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 871,900	$ 871,900			$ 28,039	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ManorCare at Urbana # 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	49,365	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	73,129	2
3. Under or (over) accrual (line 2 minus line 1).	$	23,764	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	73,129	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	96,893	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	45,176	8
1999	45,199	9
2000	45,199	10
2001	47,282	11
2002	73,129	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare at Urbana COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0027565

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	91-21-08-309-001	See Attached	$ 48,499.08	$ 48,499.08
2.	91-21-08-309-002	See Attached	$ 597.32	$ 597.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,096.40	$ 49,096.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,249 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 68,476	1
2					2
3	TOTALS			$ 68,476	3

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100			1966	$ 1,022,540	$ (35,819)		$ 35,819	$ 71,638	$ 1,685,184	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)										9
10				1984	9,538	54,131		54,131		1,168,689	10
11				1985	15,438						11
12				1986	31,912						12
13				1987	83,892						13
14				1988	11,031						14
15				1989	76,691						15
16				1990	36,584						16
17				1991	19,488						17
18				1992	197,124						18
19				1993	70,653						19
20				1994	82,201						20
21				1995	140,479						21
22	CAPITALIZED LABOR-SHOWER RM			1996	7,272						22
23	RENOVATE SHOWER ROOM			1996	18,516						23
24	UPGRADE ACTIVITY ROOM			1996	2,036						24
25	UPGRADE BOOKKEEPING OFFICE			1996	1,594						25
26	WALLVINYL/HANDRAILS 2ND FLOOR			1996	6,291						26
27	UPGRADE 10 RESIDIENT ROOMS			1996	4,441						27
28	HANDRAILS - 3RD FLOOR			1996	1,000						28
29	INSTALL CARPET			1996	2,098						29
30	WATER HEATER			1996	886						30
31	PLUMBING			1996	1,103						31
32	REFRIGERATOR COMPRESSOR			1996	1,067						32
33	WALLCOVERINGS/CORNER GUARDS			1996	1,236						33
34	PAINTING			1996	1,565						34
35	CARPET			1996	2,414						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELECTRICAL/LIGHTING	1996	$ 1,753	$		$	$	$	37
38	INSTALL FLOOR TILES	1996	5,884						38
39	RENOVATION/DECORATING	1996	1,879						39
40	INSTALL PARKING GATE	1996	3,384						40
41	HANDRAILS	1997	4,611						41
42	WALLVINYL/PAINT	1997	3,050						42
43	CEILING/WALL REPAIRS	1997	2,860						43
44	FURNISH & INSTALL TILES	1997	7,192						44
45	HOT WATER HEATER/PLUMBING	1997	5,351						45
46	ELECTRICAL	1997	2,233						46
47	RETIREMENTS	1984	(95)						47
48	RETIREMENTS	1987	(45,556)						48
49	RETIREMENTS	1992	(14,562)						49
50	WALLVINYL/PAINTING	1997	4,066						50
51	SEWER REPAIRS	1997	5,667						51
52	HVAC/EXHAUST	1997	4,902						52
53	CHILLER REPLACEMENT	1997	24,300						53
54	FACILITY PLAN ALLOC.	1997	2,759						54
55	TV INSPECTION RPT	1997	710						55
56	INSTALL EMERGENCY GENERATOR	1998	63,013						56
57	PLUMBING	1998	4,863						57
58	FLOOR TILE	1998	10,883						58
59	DRYWALL	1998	1,750						59
60	CEILING	1998	1,750						60
61	INSTALL NEW LOCKS	1998	1,202						61
62	CORPORATE OVERHEAD-ENTRYWAY	1998	1,702						62
63	CONSTRUCT LARGER ENTRYWAY	1998	1,964						63
64	ELEVATOR EQUIP EVAL.	1998	700						64
65	ROOF INSPECTION SURVEY	1998	500						65
66	MILLWORK	1998	12,203						66
67	CARPENTRY	1998	12,751						67
68	FINISH/STUD	1998	14,211						68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,996,970	$ 18,312		$ 89,950	$ 71,638	$ 2,853,873	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,996,970	$ 18,312		$ 89,950	$ 71,638	$ 2,853,873	1
2	FLOORING	1998	13,543						2
3	PAINTING/WALLCOVER	1998	31,598						3
4	GENERAL CONTRACTORS-RESIDENT ROOMS	1998	14,108						4
5	CARPETING	1998	2,879						5
6	MASONRY	1998	1,400						6
7	SIGNAGE	1998	12,197						7
8	ROOFING	1998	9,618						8
9	PLUMBING	1998	5,200						9
10	ELECTRICAL	1998	8,599						10
11	HVAC/EXHAUST (CORRECTS LINE 32, PAGE 12A)	1998	(3,600)						11
12	ELECTRICAL	1999	1,520						12
13	CONSTRUCTION, URBANA FACILITY	1999	4,044						13
14	ADVANTAGE 1000 SYSTEM, OUTLETS	1999	14,142						14
15	ELECTRONICS / COMMUNICATION	1999	2,616						15
16	STAINLESS STEEL WALLS FOR KITCHEN	1999	2,437						16
17	NEW PHONE LINES FOR RESIDENT ROOMS	2000	3,822						17
18	DOOR UPGRADES	2000	3,915						18
19	MAGNETIC DOOR HOLDERS	2000	4,046						19
20	MEDICAID ADJUSTMENT - LAND/BLDG	1995	1,241						20
21	BOILER	2000	11,400						21
22	CORNER GUARDS	2000	1,112						22
23	TILE - RESIDENT RMS 3RD FLR	2000	4,990						23
24	TILE - DIETARY	2000	10,380						24
25	VWC	2000	2,261						25
26	EXIT LIGHTS	2001	1,275						26
27	FREIGHT ON CARPET	2001	369						27
28	4" FLGD GATE VALVE	2001	844						28
29	WALLS IN TUNNEL / WALL PAPER	2001	727						29
30	CARPET	2001	7,350						30
31	PAINT & WALLPAPERING	2001	264						31
32	PAINT & WALL PAPERING	2000	3,480						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,174,747	$ 18,312		$ 89,950	$ 71,638	$ 2,853,873	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,174,747	$ 18,312		$ 89,950	$ 71,638	$ 2,853,873	1
2	CARPET	2001	4,510						2
3	CARPET & VINYL COVERING - TRIM	2001	5,385						3
4	CARPET	2001	380						4
5	PAINTING, PLUMBING, & WALL COVERING	2001	105,952						5
6	CARPET, PADS, AND WALL COVERING	2001	39,205						6
7	DESIGN COSTS	2001	63,149						7
8	ARTWORK, PLANTS	2001	6,263						8
9	TRIM IN 2 ELEVATORS	2001	2,094						9
10	REPLACE LEAKY SHOWER STALL	2001	4,589						10
11	CERAMIC FLOOR (SHOWERS)	2001	2,286						11
12	DOORS	2001	1,095						12
13	VINYL COVERING & TRIM	2001	2,390						13
14	ADJUST ASSET #1582	2001	3,661						14
15	CARPET	2001	1,094						15
16	FLOORING	2001	4,395						16
17	FLOORING	2001	2,070						17
18	EXIT DOOR	2001	3,551						18
19	DURASOL AWNING WITH HOOD	2002	4,417						19
20	FLOORING	2002	14,202						20
21	NORTH END EXIT DOOR	2002	4,187						21
22	C/R 5/31/99 AUDIT ADJ. - CAPITALIZED LABOR	1996	(7,272)	(364)		(64)	300	(2,485)	22
23	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(2,759)	(138)		(138)		(805)	23
24	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)	(85)		(85)		(411)	24
25	GENERAL CONSTRUCTION	2002	94,218						25
26	OVERHEAD AND INTEREST	2002	4,920						26
27	ELECTRICAL	2002	49,751						27
28	VINYL WALL COVERING	2002	117						28
29	MEDICAL RECORDS OFFICE CARPETING	2002	7,500						29
30	PAINTING AND VINYL WALL COVERING	2003	1,489						30
31	CARPET INSTALLATION	2003	1,078						31
32	CONV OF 2 CLOSETS TO WORK AREA	2002	1,890						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,598,854	$ 17,725		$ 89,663	$ 71,938	$ 2,850,172	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,598,854	$ 17,725		$ 89,663	$ 71,938	$ 2,850,172	1
2	MED RECORDS OFFICE SHELVING	2002	4,538						2
3	CEILING	2003	1,314						3
4	VINYL WALL COVERING	2002	692						4
5	VINYL WALL COVERING	2003	646						5
6	VINYL WALL COVERING	2003	205						6
7	CEILING TEXTURE	2003	475						7
8	FLOORING	2003	3,250						8
9	PAINTING	2003	990						9
10	PAINTING-RETAINAGE	2003	110						10
11	ARCHITECT & ENGINEERING COSTS	2002	1,049						11
12	CARPET AND INSTALLATION	2002	1,950						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,614,073	$ 17,725		$ 89,663	$ 71,938	$ 2,850,172	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 716,666	$ 28,891	$ 28,891	$		$ 574,266	71
72	Current Year Purchases	80,901						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			30,865	30,865			74
75	TOTALS	$ 797,567	$ 28,891	$ 59,756	$ 30,865		$ 574,266	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,480,116	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,616	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,419	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 102,803	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,424,438	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 15,013 Description: O2 Concentrators, Wheelchairs, Gerichairs, Electric Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	5417 hrs	$ 127,634	435	$ 10,887	$ 2,447	5,852	$ 140,968	1
2	Licensed Speech and Language Development Therapist	10a	2537 hrs	59,765	152	3,799	252	2,689	63,816	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7115 hrs	167,640	553	13,814	3,156	7,668	184,610	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				190,061		190,061	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab, X-Ray,Inhala	10a, 39 Col 3				17,308			17,308	13
14	TOTAL			$ 355,039	1,140	$ 45,808	$ 195,916	16,209	$ 596,763	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ManorCare at Urbana # 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,418	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (153,159))	676,516		3
4	Supply Inventory (priced at)	8,232		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,641		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 812,807	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,476		13
14	Buildings, at Historical Cost	2,614,072		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	797,567		16
17	Accumulated Depreciation (book methods)	(3,424,438)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 55,677	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 868,484	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,050	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,651		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,129		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	68,815		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 394,645	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 394,645	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 473,839	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 868,484	$	48

***(See instructions.)**

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 541,856	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 541,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,726	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 35,726	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(103,743)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (103,743)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 473,839	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,548,207	1
2	Discounts and Allowances for all Levels	(1,348,552)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,199,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,362,512	6
7	Oxygen	4,041	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,366,553	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,748	12
13	Barber and Beauty Care	10,069	13
14	Non-Patient Meals	192	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,620	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,027	19
20	Radiology and X-Ray		20
21	Other Medical Services	702	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 232,358	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,783	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,783	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	5,218	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,218	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,805,567	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	755,130	31
32	Health Care	2,041,798	32
33	General Administration	1,481,249	33
	B. Capital Expense		
34	Ownership	179,758	34
	C. Ancillary Expense		
35	Special Cost Centers	311,906	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,769,841	40
41	**Income before Income Taxes (line 30 minus line 40)****	35,726	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 35,726	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	822	879	$ 22,234	$ 25.29	1
2	Assistant Director of Nursing	3,444	3,682	80,299	21.81	2
3	Registered Nurses	11,550	12,350	233,060	18.87	3
4	Licensed Practical Nurses	19,952	21,333	341,795	16.02	4
5	Nurse Aides & Orderlies	65,573	70,112	662,793	9.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,035	15,068	355,033	23.56	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,068	4,367	42,844	9.81	10
11	Social Service Workers	5,311	5,604	78,421	13.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,021	22,573	203,930	9.03	15
16	Dishwashers					16
17	Maintenance Workers	2,400	2,581	35,689	13.83	17
18	Housekeepers	11,220	12,055	104,172	8.64	18
19	Laundry	4,194	4,504	38,335	8.51	19
20	Administrator	2,071	2,071	57,459	27.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,513	13,620	200,452	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,661	2,862	26,441	9.24	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,835	193,661	$ 2,482,957 *	$ 12.82	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,965	5,1,3	35
36	Medical Director	Monthly	9,000	5,9,3	36
37	Medical Records Consultant	Monthly	983	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,469	5,11,3	44
45	Social Service Consultant	Monthly	1,202	5,12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,619		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jan Thomen	Administrator	0	$ 9,577
Doug Daudelin	Administrator	0	47,882
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 57,459

B. Administrative - Other

Description	Amount
Management Fees	$ 301,592
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 301,592

C. Professional Services

Vendor/Payee	Type	Amount
Van,Ostrand & Elvidge Kelly	Legal Fees	$ 452
Baltimore City Dept Soc Svcs	Consulting Fees	579
Grantly,Payne and Assoc	Consulting Fees	2,306
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 3,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 252,927
Unemployment Compensation Insurance	26,449
FICA Taxes	176,083
Employee Health Insurance	170,660
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Overhead Allocated	1
401K	4,831
Other Employee Benefits	8,846
Tuition Program	1,125
Disability Payments	4,528
Home Office Allocation	48,815
TOTAL (agree to Schedule V, line 22, col.8)	$ 694,265

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 645
Advertising: Employee Recruitment	10,862
Health Care Worker Background Check (Indicate # of checks performed 52)	1,040
Dues & Subscriptions	1,019
Association Dues	4,529
Advertising	16,647
Less: Non-allowable Association Dues	(1,617)
Less: Public Relations Expense	( )
Non-allowable advertising	(14,481)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,179
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,804

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ManorCare at Urbana # 0027565 Report Period Beginning: 06/01/02 Ending: 05/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ManorCare at Urbana **#** 0027565 **Report Period Beginning:** 06/01/02 **Ending:** 05/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 4529**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $1,617**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,355** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,750**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(192)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.